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Living Will Statutes: A Proposal For Kentucky

Michelle Coulter Landers
University of Kentucky

Comments

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INTRODUCTION

Recent breakthroughs in medical technology have resulted in indefinitely prolonging lives[1] of wholly or partially "brain dead"[2] patients. The numerous medical, ethical and legal problems created by these accomplishments, however, must be addressed.[3]

The living will,[4] statutorily adopted by a majority of states,[5] is one method of dealing with these problems. The statutory

[1] *In re* L.H.R., 321 S.E.2d 716, 722 (Ga. 1984); Superintendent of Belchertown State School v. Saikewicz, 370 N.E.2d 417, 423 (Mass. 1977); *In re* Conroy, 486 A.2d 1209, 1220 (N.J. 1985).

Some technological advances which enable the medical profession to prolong life are respirators, heart-lung machines, pacemakers, artificial or transplanted organs, hemodialysis and drug therapy. Comment, *Living Wills—A Need for Statewide Legislation or a Federally Recognized Right?*, 1983 DET. C.L. REV. 781, 781 n.1 (1983) [hereinafter Comment, *Living Wills—A Need for Statewide Legislation*]; Comment, *The Living Will: Already a Practical Alternative*, 55 TEX. L. REV. 665, 666 (1977).

[2] Although the definition of brain death is one controversial aspect of the right to die issue, this issue is beyond the scope of this Comment. The author suggests, however, that the best definition of brain death is the Uniform Determination of Death Act, developed and proposed by the American Bar Association, the American Medical Association, and the National Conference of Commissioners on Uniform State Laws. The definition follows: "An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards." PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE SUSTAINING TREATMENT 9 n.7 (1983) [hereinafter PRESIDENT'S COMMISSION REPORT].

[3] *See* 321 S.E.2d at 722; 370 N.E.2d at 423; *In re* Torres, 357 N.W.2d 332, 341 (Minn. 1984); Note, *The "Living Will": The Right to Death With Dignity?*, 26 CASE. W. RES. 485, 486 (1975-76); Comment, *Living Wills—A Need for Statewide Legislation*, *supra* note 1, at 781-82.

[4] "Living will" describes a document whereby a person can direct in advance that life support systems shall be terminated in the event that the patient is in a terminal condition. It is, in effect, a recognition of the right to die. The term living will was first used by Luis Kutner in 1969. *See* Martyn & Jacobs, *Legislating Advance Directives for the Terminally Ill: The Living Will and Durable Power of Attorney*, 63 NEB. L. REV. 779, 787 (1984).

[5] *See* note 80 *infra*.

method of dealing with the "right to die"[6] issue seems to be the best approach to the problem.[7] The Kentucky legislature has failed to address this issue,[8] leaving the decision of whether or not to continue life support systems to physicians and family members who may not know the wishes of a particular patient.[9]

Questions surrounding a person's right to choose whether or not to die and whether living wills should be given legal effect through statutes are emotional issues.[10] The emotions of individ-

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[6] The question of whether a person has the "right to die" has been debated extensively on both moral and legal grounds. *See, e.g.*, S. SHINDELL, THE LAW IN MEDICAL PRACTICE 116-118 (1966); Elkinton, *The Dying Patient, the Doctor, and the Law*, 13 VILL. L. REV. 740 (1968); Gelfand, *Euthanasia and the Terminally Ill Patient*, 63 NEB. L. REV. 741 (1984); Kamisar, *Some Non-Religious Views Against Proposed "Mercy Killing" Legislation*, 42 MINN. L. REV. 969 (1958); Kutner, *Due Process of Euthanasia: The Living Will, a Proposal*, 44 IND. L.J. 539 (1969).

[7] *See* 486 A.2d at 1220-21; Note, *The Tragic Choice: Termination of Care for Patients in a Permanent Vegetative State*, 51 N.Y.U.L. REV. 285, 297 (1976) (legislatures better suited to balance interests in determining whether to permit termination of care); Comment, *Living Wills—A Need for Statewide Legislation*, *supra* note 1, at 825. *Contra* Martyn & Jacobs, *supra* note 4.

[8] Living will bills have been presented to the Kentucky Legislature for consideration in each of the last three meetings of the general assembly.

The Kentucky General Assembly meets for sixty legislative days beginning on the first Tuesday after the first Monday in January of even-numbered years. KY. CONST. §§ 36, 42. The next scheduled meeting of the general assembly is January, 1988.

During the most recent session of the general assembly (January, 1986), HB138 (BR 143) sponsored by Gerta Bendl, D-Louisville, was presented to the Judicial-Civil Committee on January 8. The bill was posted in Committee on February 4. On February 13, after testimony was given by both sides, the vote was tied on whether to send the bill to the House for consideration and so the posting was withdrawn. The bill never got the consideration and debate of the full House of Representatives. 17 LEGIS. RECORD 60 (daily ed. April 15, 1986).

[9] In the case of an individual who has not expressed his wishes in the event that he is unable to make decisions for himself, the family is faced with a difficult decision, at an even more difficult time. Not only is it possible that physicians and/or family members may guess wrong about the patient's true wishes, it is additionally possible that the patient's true wishes could be deliberately frustrated. Many physicians are afraid of possible civil or criminal liability and thus are unwilling to make the decision for the patient. In the absence of some legally enforceable expression of the patient's wishes, it is possible for a family that knows the patient would not want to be kept alive by extraordinary means to keep the patient alive by not divulging the patient's true wishes.

[10] There are groups on each side of the issue who spend much time and effort lobbying for their cause. In Kentucky the chief opponent of such a law is the Kentucky Right to Life Association. Lexington Herald-Leader, Apr. 5, 1986, at B1, col. 1. The issue is an emotional one because it deals with a very difficult subject: death. Kutner, *The Living Will—Coping With the Historical Event of Death*, 27 BAYLOR L. REV. 39,

ual legislators and third-parties, however, should not prevent the legislative adoption of a policy based on facts concerning living wills and the legal effects of those documents.[11]

This Comment addresses some of the issues that the Kentucky legislature and other state legislatures may face in adopting a living will statute. The first section presents arguments for and against adoption of such a statute. The second section examines relevant portions of other state statutes and offers a model statute (based on these other statutes and the author's own opinions) for adoption by the Kentucky legislature.

I. REASONS FOR AND AGAINST A STATUTE

A. The Right of Privacy

The right of privacy is not expressly enunciated in the United States Constitution. While the source of this right has been a matter of considerable disagreement among members of the Supreme Court, a majority of the Court consistently has agreed that the right to personal privacy does exist. The concept was first enunciated in Justice Brandeis's dissent in *Olmstead v.*

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39 (1975) ("Ever since recorded humankind there have been reflections on death and the continuity of life . . . . Anthropologically every culture has cultivated a pornography of death. . . . Discussion of death and the life cycle are taboo to the advocates of symbolic immortality."); Comment, *The Right to Die: An Extension of the Right to Privacy*, 18 JOHN MARSHALL L. REV. 895, 896 (1984-85) ("In a life-oriented society the expression of a desire to die is often controversial and misunderstood.").

[11] The Kentucky Right to Life Association generally has kept a high profile in lobbying the Kentucky General Assembly. The organization has been fairly successful in encouraging passage of legislation that comports with its viewpoint. The group, however, usually has engaged in lobbying tactics that involve the use of highly emotional charges. For example, in testifying at the Judiciary-Civil Committee hearing on the living will bill, the Right to Life group "argued that living wills would give physicians a license to kill their patients." Lexington Herald-Leader, Feb. 16, 1986, at F2, col. 1. The living will statutes passed by a majority of states and the bill proposed by Gerta Bendl do not give physicians a "license to kill." These charges merely detract from the real facts and issues that should be considered by the legislators. The living will does not give physicians a "license to kill" for a number of reasons: First, the decision to terminate treatment is not made by the physician. The patient, through the living will, exercises his right to die and the physician merely follows his patient's treatment decision. Second, physicians are not "killing," they are "allowing patients to die naturally." It is implausible that physicians, after taking an oath to heal, will run rampant and kill patients, simply because a living will statute is enacted.

United States.[12] He stated: "The makers of our Constitution . . . sought to protect Americans in their beliefs, their thoughts, their emotions, and their sensations. They conferred, as against the Government, the right to be let alone—the most comprehensive of rights and the right most valued by civilized men."[13]

Thirty-seven years later the United States Supreme Court expressly recognized the right to privacy in *Griswold v. Connecticut*.[14] The *Griswold* case dealt with a Connecticut statute which forbade the use of contraceptives by married couples and made it a crime to distribute birth control information. The Court invalidated the statute as an undue infringement of a "zone of privacy,"[15] and, therefore, impermissible absent some compelling state interest. Although the justices did not agree on the source of the right to privacy, a majority believed it existed in the "penumbra" of provisions in the Bill of Rights.[16]

The right to privacy was expanded by the United States Supreme Court in *Roe v. Wade*.[17] In *Roe* the Court held that, within certain limits,[18] a woman has the right to decide whether or not to have an abortion. The Court held that the woman's right to make this choice stemmed from her right of privacy and found this right of privacy in the Fourteenth Amendment's concept of liberty.[19]

The right of privacy was subsequently extended to protect an individual's decision to forego or terminate life sustaining medical treatment.[20] This extension of the right of privacy was

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[12] 277 U.S. 438 (1928).

[13] *Id.* at 478.

[14] 381 U.S. 479 (1965).

[15] *Id.* at 484.

[16] *Id.* at 482-85 (provisions in the Bill of Rights included the first, fourth, fifth, and ninth amendments).

[17] 410 U.S. 113 (1973).

[18] Under the *Roe* decision a woman is limited in her ability to choose to have an abortion according to the trimester of pregnancy. During the first trimester the state cannot interfere in the decision, during the second trimester the state may regulate abortions in order to protect maternal health, and during the third trimester the state may prohibit abortions altogether. *Id.* at 163-64.

[19] *Id.* at 153-54.

[20] Tune v. Walter Reed Army Medical Hosp., 602 F. Supp. 1452 (D.D.C. 1985) (extending the right to patients in federal facilities); Foody v. Manchester Memorial Hosp., 482 A.2d 713 (Conn. 1984); Satz v. Perlmutter, 362 So. 2d 160 (Fla. Dist. Ct.

first recognized by the New Jersey Supreme Court in the well-known case *In re Quinlan*.[21] In this case, Karen Quinlan was declared to be in a "chronic vegetative state" by her physicians.[22] Her father, as guardian, petitioned the court to allow him to terminate the medical procedures that were sustaining her life.[23] The New Jersey court, recognizing the right to privacy, allowed the father to order the termination of her life support systems. The court held: "[the right to privacy] is broad enough to encompass a patient's decision to decline medical treatment under certain circumstances."[24]

Other courts followed the *Quinlan* decision.[25] *In re Conroy*, a recent New Jersey decision, extended the right of privacy to include the ability to decline life sustaining treatment.[26] The *Conroy* court held that life sustaining treatment may be withheld or withdrawn from an incompetent patient when it is clear that the particular patient, if competent, would have refused the treatment under the circumstances.[27] The court, however, recognized that the right is not absolute and must be weighed against competing state interests. "Courts and commentators[28] have commonly identified four state interests that may limit a person's right to refuse medical treatment: preserving life; pre-

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App. 1978); *In re* L.H.R., 321 S.E.2d 716 (Ga. 1984); Brophy v. New England Sinai Hosp., Inc., 497 N.E.2d 626 (Mass. 1986); *In re* Spring, 405 N.E.2d 115 (Mass. 1980); Superintendent of Belchertown State School v. Saikewicz, 370 N.E.2d 417 (Mass. 1977); *In re* Torres, 357 N.W.2d 332 (Minn. 1984); *In re* Conroy, 486 A.2d 1209 (N.J. 1985); *In re* Storar, 420 N.E.2d 64 (N.Y.), *cert. denied*, 454 U.S. 858 (1981).

[21] 355 A.2d 647 (N.J. 1976).

[22] *Id.* at 654. The phrase "chronic vegetative state" is defined by Dr. Fred Plum, a medical expert in the Quinlan case, as a state in which there is a "capacity to maintain the vegetative parts of neurological function but [the patient] . . . no longer has any cognitive function." *Id.*

[23] *Id.* at 653.

[24] *Id.* at 663.

[25] *See* note 20 *supra*.

[26] 486 A.2d 1209 (N.J. 1985).

[27] *Id.* at 1229.

[28] The *Conroy* court identifies the following sources supporting its position: 362 So. 2d at 162; 405 N.E.2d at 123; Commissioner of Correction v. Myers, 399 N.E.2d 452, 456 (Mass. 1979); 370 N.E.2d at 425; 357 N.W.2d at 339; *In re* Colyer, 660 P.2d 738, 743 (Wash. 1983); PRESIDENT'S COMMISSION REPORT, *supra* note 2, at 31-32; Note, In re Storar: *The Right to Die and Incompetent Patients*, 43 U. PITT. L. REV. 1087, 1092 (1982).

venting suicide; safeguarding the integrity of the medical profession; and protecting innocent third parties."[29]

Preserving life is the most compelling and significant state interest.[30] "It may be seen as embracing two separate but related concerns: an interest in preserving the life of the particular patient, and an interest in preserving the sanctity of all life."[31] These concerns are strong, but unless there is an interest in preserving the life of someone other than the patient, the state's interest in preserving life will usually succumb to the patient's much stronger right of free choice and self-determination.[32]

Many states have an interest in preventing suicide.[33] This interest is arguably an extension of the interest in preserving life.[34] There is a difference between committing an act of suicide and refusing medical treatment.[35] A person who refuses medical treatment "may fervently wish to live," but would like "to do so free of unwanted medical technology, surgery or drugs."[36] When making the decision to terminate or refuse medical treatment, the patient is not committing an act of suicide but "merely allows the disease to take its natural course. . . ."[37] This refusal

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[29] 486 A.2d at 1223. *See also* 482 A.2d at 718; 497 N.E.2d at 634.

[30] 486 A.2d at 1223.

[31] *Id.*

[32] 370 N.E.2d at 426-27.

[33] Suicide was a felony at common law, punishable by forfeiture of the goods and chattels of the offender and the ignominious burial of his body in the highway. In some jurisdictions it is still considered a felony or a crime and the incidents of a criminal act may follow therefrom. In other jurisdictions, however, suicide itself is not a crime and is not punishable as such. . . .

83 C.J.S. *Suicide* § 2 (1953). "If the act of suicide fails to accomplish its purpose, it constitutes an attempt to commit suicide, which is unlawful and criminal, and an indictable offense both at common law and under some statutes." 83 C.J.S. *Suicide* § 3 (1953).

[34] 486 A.2d at 1224 (state's interest in preventing suicide motivated by interest in protecting life).

[35] "The difference is between self-infliction or self-destruction and self-determination." *Id.*

[36] *Id.* (citing 362 So. 2d at 162-63; 370 N.E.2d at 426 n.11).

[37] *Id.* This distinction most often is termed as the difference between euthanasia and antidysthanasia. Euthanasia "has been defined as the taking of positive action to end the life of an incurable patient," whereas "[a]ntidysthanasia has been defined as the 'failure to take positive action to prolong the life of an incurable patient with intractable pain.' " Note, *supra* note 3, at 487 (quoting SHINDELL, *supra* note 6, at 118).

clearly differentiates the termination decision from suicide because if death eventually occurs, it will be the result of natural causes, not self-inflicted injury.[38]

The third interest often asserted by states is preservation of the integrity of the medical profession.[39] Surveys indicate, however, that a majority of doctors approve of "passive euthanasia",[40] and believe it is being practiced by members of their profession.[41] Physicians are not required by any standards or rules of ethics to intervene at all costs to save a patient's life.[42]

Accord Note, *Statutory Recognition of the Right to Die: The California Natural Death Act*, 57 B.U.L. REV. 148 (1977) [hereinafter Note, *Statutory Recognition*]; Note, *Voluntary Active Euthanasia for the Terminally Ill and the Constitutional Right to Privacy*, 69 CORNELL L. REV. 363 (1984). *But see* Comment, *The Right to Die*, 7 HOUS. L. REV. 654, 659 (1969-70) ("[I]t is submitted that once life support equipment has begun to operate on a patient, it is falacious [sic] to argue that a cessation of such treatment is a mere 'omission to provide therapeutic treatment' and is not an 'act' in a legal sense.").

[38] [T]he underlying State interest in [preventing suicide] lies in the prevention of irrational self destruction. What we consider here is a competent, rational decision to refuse treatment when death is inevitable and the treatment offers no hope of cure or preservation of life. There is no connection between the conduct here in issue and any state concern to prevent suicide.

370 N.E.2d at 426 n.11 (citation omitted). *See also* 362 So. 2d at 162-63; 486 A.2d at 1224.

[39] 486 A.2d at 1224.

[40] *See* note 37 *supra* (distinguishing "passive euthanasia" (antidysthanasia) from active euthanasia (euthanasia)).

[41] 486 A.2d at 1225. *See* Levisohn, *Voluntary Mercy Deaths*, 8 J. FOR MED. 57, 68 (1961) (61 percent of physicians surveyed believed euthanasia was practiced by members of profession); Travis, Noyes & Brightwell, *The Attitudes of Physicians Toward Prolonging Life*, 5 INT'L. J. OF PSYCHIATRY IN MED. 18, 19 (1974) (44 percent of respondents frequently omitted life prolonging procedures and medications and 47 percent said they would be more inclined to do so if the patient had signed a statement that prolonging measures should not be used); *Euthanasia*, 218(1) J. A.M.A. 249 (1971) (80 percent of physicians questioned practiced euthanasia); *Euthanasia Questions Stir New Debate*, Med. World News, Sept. 14, 1973, at 75 (87 percent of respondents to a poll done by the Association of American Physicians approved passive euthanasia).

[42] 486 A.2d at 1224.

Prevailing medical practice does not, without exception, demand that all efforts toward life prolongation be made in all circumstances. Rather, as indicated in *Quinlan*, the prevailing ethical practice seems to be to recognize that the dying are more often in need of comfort than treatment. Recognition of the right to refuse necessary treatment in appropriate circumstances is consistent with existing medical mores. . . .

370 N.E.2d at 426. "[P]hysicians have begun to realize that in many cases the effect of using extraordinary measures to prolong life is 'only to prolong suffering, isolate the

When a doctor has informed the patient of the risks involved in treatment, the ultimate treatment decision rests with the patient.[43] It seems, therefore, that it is unnecessary for the state to protect the medical profession. The integrity of the doctor and the medical profession is not impaired by a patient's informed decision. Because the medical profession apparently does not believe that its integrity is being impaired, an argument that the state has an interest in preserving that integrity is not persuasive.

"The fourth asserted state interest in overriding a patient's decision about his medical treatment is the interest in protecting innocent third parties who may be harmed by the patient's treatment decision."[44] It is in this area that the state's interest most often has been deemed to outweigh the patient's right to privacy.[45] Competent adults have been forced, against their will, to undergo medical procedures when they jeopardized public health[46] or posed a risk to prison security.[47] In *Application of President and Directors of Georgetown College, Inc.*,[48] the mother of a seven month old baby, because of her responsibility to the baby and to the community, was forced to have a blood transfusion despite her religious objections to this procedure.[49]

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family from their loved one at a time when they may be close at hand or result in economic ruin for the family.' " *Id.* at 423 (citing Lewis, *Machine Medicine and It's Relation to the Fatally Ill*, 206 J. A.M.A. 387 (1968)).

The physician's role toward the terminally ill was formulated by the American Medical Association: "The social commitment of the physician is to prolong life and relieve suffering. Where the observance of one conflicts with the other, the physician, patient and/or family of the patient have the discretion to resolve the conflict." JUDICIAL COUNCIL, CURRENT OPINIONS OF THE JUDICIAL COUNCIL OF THE AMERICAN MEDICAL ASSOCIATION, AMERICAN MEDICAL ASSOCIATION, CHICAGO (1982) at 9 (cited in PRESIDENT'S COMMISSION REPORT, *supra* note 2, at 31-32).

[43] *See* notes 52-74 *infra* and accompanying text.

[44] 486 A.2d at 1225.

[45] *Id.* at 1225-26.

[46] Graybeal v. McNevin, 439 S.W.2d 323 (Ky. 1969) (flouridation of water systems held valid on basis that Board of Health determined it was in public interest, despite claim that it violated right to religious freedom).

[47] Commissioner of Correction v. Myers, 399 N.E.2d 452 (Mass. 1979) (prisoner forced to undergo dialysis rather than be transferred to lower security prison).

[48] 331 F.2d 1000 (D.C. Cir.), *cert. denied*, 377 U.S. 978 (1964).

[49] The mother was a Jehovah's Witness, the teachings of which prohibit the injection of blood into the body. *See id.* at 1002.

The right to privacy and self-determination generally have been held to outweigh competing state interests.[50] Because courts have raised the right to privacy (thus the right to choose to die) to a constitutional level, the legislature must formulate clear standards regarding how this right can be exercised.[51] This can and should be done through the adoption of a living will statute.

B. Informed Consent

Under the doctrine of informed consent, "no medical procedure may be performed without a patient's consent, obtained after explanation of the nature of the treatment, substantial risks, and alternative therapies."[52] Informed consent protects the patient's right to privacy[53] but a person's "ability to control his bodily integrity through informed consent is significant only when one recognizes that this right also encompasses a right to informed refusal."[54] Without the ability to refuse treatment, consent has no meaning. If the patient cannot refuse treatment, why "inform him" at all?

Luis Kutner has advocated the use of the living will for many years.[55] He proposed a document which "would provide that if the individual's bodily state becomes completely vegetative and it is certain that he cannot regain his mental and physical ca-

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[50] 486 A.2d at 1225. *See also* Bartling v. Superior Court of Cal., 209 Cal. Rptr. 220, 224-26 (1984) (states' interests do not prevail over the right of a competent adult to choose to die by refusing to continue life support systems).

[51] The legislature has the power to make laws for the public health, safety and welfare. Legislation would also provide a clear and helpful framework for the courts. Note, *The Tragic Choice: Termination of Care for Patients in a Permanent Vegetative State*, 51 N.Y.U. L. REV. 285, 297-98 (1976).

[52] 486 A.2d at 1222 (quoting Cantor, *A Patient's Decision to Decline Life Saving Medical Treatment: Bodily Integrity Versus the Preservation of Life*, 26 RUTGERS L. REV. 228, 237 (1973)).

[53] "The doctrine . . . is a primary means . . . to protect this personal interest in the integrity of one's body." *Id.*

[54] *Id.* (citing Note, *Informed Consent and the Dying Patient*, 83 YALE L.J. 1632, 1648 (1974)); Kutner, *supra* note 10, at 47 ("Hence if courts take *Informed Consent* seriously they must recognize the right of a competent patient to forego treatment.") (emphasis in original).

[55] Luis Kutner is a member of the Illinois and Indiana Bars, is a former Visiting Associate Professor at Yale Law School and was Chairman of the World Habeas Corpus Committee. Kutner first proposed the living will in 1969 in an article entitled *Due Process of Euthanasia: The Living Will, a Proposal*, 44 IND. L.J. 539 (1969).

pacities, medical treatment shall cease."[56] In making the proposal for the living will, Kutner stated: "The essence of the *Living Will* is *Informed Consent* of the person prior to the status of irreversibility of dying or being maimed."[57] Kutner reasoned that informed consent is an exercise of the right of privacy that "should not be interfered with."[58]

The doctrine of informed consent is a part of the contractual nature of the physician/patient relationship.[59] Once the patient seeks a physician's services and the physician accepts, the physician has a duty to continue treatment until the physician/patient relationship is terminated.[60] Although the physician has this duty, he is liable for battery if he performs treatment without the patient's informed consent.[61]

When an individual is unable to consent, as in an emergency situation, the physician must assume that the patient would want measures taken to preserve his life.[62] What if this assumption is incorrect? The living will is useful in this situation. A living will allows a person to sign a document indicating the extent to which he would consent to medical treatment in the event that he becomes unable to express himself on the issue.[63]

Commentators have criticized living wills stating that due to their speculative nature they cannot possibly represent informed consent.[64] But by directing in advance the preference not to have

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[56] Kutner, *supra* note 10, at 48.

[57] *Id.* at 46.

[58] *Id.*

[59] Note, *supra* note 3, at 491-94.

[60] *Id.* at 492. Doan v. Griffith, 402 S.W.2d 855 (Ky. 1966) (affirming rule that a physician is under the duty to give his patient all necessary and continued attention as long as the case requires it).

[61] *See generally* W. KEETON, PROSSER AND KEETON ON THE LAW OF TORTS § 18, at 114-18 (5th ed. 1984).

[62] KEETON, *supra* note 61, at 117 ("[I]t has often been asserted that a physician or other provider of health care has implied consent to deliver medical services . . . to a patient in an emergency."); Kutner, *supra* note 10, at 47; Note, *Statutory Recognition*, *supra* note 37, at 163; Note, *supra* note 3, at 494.

[63] Kutner, *supra* note 10, at 47-48. *Accord* Note, *Statutory Recognition*, *supra* note 37, at 163-64.

[64] It has been contended that an ordinary person could not understand the type of treatment he would want when dying. [footnote omitted] As Dr. Austin Kutscher has noted: "An individual signs it under circumstances when he is not concerned with his own death. It becomes operative at a

extraordinary[65] measures taken to preserve his life, a patient implicitly understands and acknowledges that he is making this decision without knowing exactly what may happen to him in the future.[66] This procedure *is* consistent with informed consent because "[v]oluntary execution of a binding power directive would provide conclusive evidence that the individual has weighed the factors favoring and opposing an 'incompletely' informed consent and has chosen to remove the decision to prolong his life from the physician's discretion."[67] It is also consistent with informed consent: the medical judgment of the patient's condition as terminal is left with the physician; the decision of whether medical treatment will continue is left where it should be—with the patient.[68]

The informed consent doctrine should not be limited to the non-terminal patient.[69] The principle of self-determination, which underlies the doctrine of informed consent,[70] should be extended to the terminal patient as well. The patient's decision of whether to institute extraordinary medical procedures, which merely postpone death, can and should be made prior to his incapacity.[71] The ability to give informed consent in advance can and should be permitted through the use of a living will. The living will, however, must be legitimized through a statute which recognizes

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time when he is 100 percent involved."

Note, *supra* note 3, at 515 (citing Dempsey, *The Living Will—And the Will to Live*, N.Y. Times, June 23, 1974, § 6 (Magazine), at 12). *See also* Kamisar, *supra* note 6.

[65] Ordinary means are "all medicines, treatments and operations which offer a reasonable hope of benefit, and which can be obtained and used without excessive expense, pain, or other inconvenience," while extraordinary means are "those which do involve these factors, or which, if used, would not offer a reasonable hope of benefit."

Note, *supra* note 3, at 495 (quoting N. ST. JOHN-STEVAS, LIFE, DEATH AND THE LAW 275-76 (1961)). *See also*, Foody v. Manchester Memorial Hosp., 482 A.2d 713, 719 (Conn. 1984) ("Ordinary care is obligatory . . . extraordinary care is optional.").

[66] Note, *Statutory Recognition*, *supra* note 37, at 164. *Cf.* Kutner, *supra* note 10 at 49-50 (patient via living will recognizes that he desires non-heroic treatment at time when actual consent would be impossible); Note, *supra* note 3, at 515-16.

[67] Note, *Statutory Recognition*, *supra* note 37, at 164.

[68] *Id.*

[69] If this decision cannot be made in advance, the person who becomes incapable of giving informed consent is deprived of his right to do so. *See* note 66 *supra*.

[70] *See* text accompanying note 54 *supra*.

[71] *See* note 66 *supra* and accompanying text.

its validity or it will not be legally binding. In the absence of a statute, the living will is merely evidence of the individual's intent[72] and may be morally persuasive to the family and the physician but is not binding on them.[73] The physician and the patient, however, need legal protection for their decisions. This protection can come only by making living wills legally binding and effective.[74]

II. THE STATUTE

A. Living Will Statutes in General

Although courts have been willing to allow a person to discontinue life prolonging measures, on the basis of either the right to privacy[75] or the informed consent doctrine,[76] the statutory approach to solving the right to die problem is best.[77] The adoption of a living will statute provides certainty regarding how a person can exercise his right to die a natural death.[78]

The statutory solution, first used by California in 1977,[79] has been adopted in a number of states.[80] The California statute

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[72] 486 A.2d at 1229 and n.5.

[73] Comment, *Living Wills—A Need for Statewide Legislation*, *supra* note 1, at 816; Comment, *The Right to Die a Natural Death and the Living Will*, 13 TEX. TECH. L. REV. 99, 126 (1982).

[74] The physician would be protected and not be held liable for his decision to follow the directive and the patient would have his right to make this decision safeguarded. *See* Note, *supra* note 3, at 525; note 73 *supra*.

[75] Tune v. Walter Reed Army Medical Hosp., 602 F. Supp. 1452 (D.D.C. 1985); Bartling v. Superior Court of Cal., 209 Cal. Rptr. 220 (1984); Satz v. Perlmutter, 362 So. 2d 160 (Fla. Dist. Ct. App. 1978); *In re* L.H.R., 321 S.E.2d 716 (Ga. 1984); *In re* Spring, 405 N.E.2d 115 (Mass. 1980); Superintendent of Belchertown State School v. Saikewicz, 370 N.E.2d 417 (Mass. 1977); *In re* Torres, 357 N.W.2d 332 (Minn. 1984); *In re* Conroy, 486 A.2d 1209 (N.J. 1985); *In re* Quinlan, 355 A.2d 647 (N.J. 1976).

[76] 370 N.E.2d 417; 486 A.2d 1209; *In re* Quackenbush, 383 A.2d 785 (N.J. Cty. Ct. 1978).

[77] *See* note 9 *supra*.

[78] Note, *The Legal Aspects of the Right to Die: Before and After the* Quinlan *Decision*, 65 KY. L.J. 823, 872 (1976-77).

[79] CAL. HEALTH & SAFETY CODE §§ 7185-7195.

[80] ALA. CODE §§ 22-8A-1 to -10 (1984); ARIZ. REV. STAT. ANN. §§ 36-3201 to -3210 (1986); ARK. STAT. ANN. §§ 82-3801 to -3804 (Cum. Supp. 1985); CAL. HEALTH & SAFETY CODE §§ 7185 - 7195 (West Cum. Supp. 1985); COLO. REV. STAT. §§ 15-18-101 to -113 (Supp. 1985); CONN. GEN. STAT. ANN. 85-606, §§ 1 - 6 (Supp. 1986); DEL. CODE

probably was precipitated by the *In re Quinlan* decision.[81] After California adopted a living will statute, other states soon followed.[82] Between 1977 and 1979 interest in the issue appears to have waned: no new statutes were adopted during this period.[83] The number of statutes recently adopted, however, indicates an apparent resurgence of interest in the issue.[84]

The adopted states' statutes vary in content. Some of the provisions of these statutes should be included in any proposed or adopted living will statute. Other provisions require refinement. Certain provisions are not found in all statutes, but are important enough to merit inclusion in any legislation passed by the Kentucky General Assembly. The following discussion indicates which provisions should be included in the statute and the reasons for their inclusion.

ANN. tit. 16, §§ 2501 - 2508 (1983); D.C. CODE ANN. §§ 6-2421 to -2430 (Cum. Supp. 1985); FLA. STAT. ANN. §§ 765.01 - .15 (West 1986); GA. CODE ANN. §§ 31-32-1 to -12 (1985); IDAHO CODE §§ 39-4501 to -4508 (1985); ILL. ANN. STAT. ch. 110 1/2, §§ 701 - 710 (Smith-Hurd Cum. Supp. 1985); IND. CODE ANN. §§ 16-08-11-1 to -11-22 (Burns Supp. 1986); IOWA CODE ANN. §§ 144A.1 - .11 (West Cum. Supp. 1986); KAN. STAT. ANN. §§ 65-28,101 - 28,109 (1980); LA. REV. STAT. ANN. §§ 1299.58.1 - .10 (West Cum. Supp. 1986); ME. REV. STAT. ANN. tit. 22, §§ 2921 - 2931 (Supp. 1985); MD. PUB. HEALTH CODE ANN. §§ 5-601 to -614 (Supp. 1986); MISS. CODE ANN. §§ 41-41-101 to -121 (Cum. Supp. 1985); MO. REV. STAT. §§ 459.010 - .055 (Supp. 1986); MONT. CODE ANN. §§ 50-9-101 to -206 (1985); NEV. REV. STAT. §§ 449.540 - .690 (1983); N.H. REV. STAT. ANN. §§ 137-H:1 to -H:16 (Supp. 1985); N.J. REV. STAT. §§ 52:9Y-1 to -6 (1986) (statute creates commission); N.M. STAT. ANN. §§ 24-7-1 to -11 (Cum. Supp. 1981); N.C. GEN. STAT. §§ 90-320 to -323 (1981); OKLA. STAT. ANN. tit. 60, §§ 3101 - 3111 (West Supp. 1986); OR. REV. STAT. §§ 97.050 - .090 (1981); TENN. CODE ANN. §§ 32-11-101 to -110 (Supp. 1986); TEX. REV. CIV. STAT. ANN. art. 4590h, §§ 1 - 11 (Vernon Cum. Supp. 1985); UTAH CODE ANN. §§ 75-2-1101 to -1118 (Supp. 1986); VT. STAT. ANN. tit. 18, §§ 5251 - 5262 (Cum. Supp. 1985); VA. CODE ANN. §§ 54.-325.8:1 - .8:13 (Cum. Supp. 1986); WASH. REV. CODE §§ 70.122.010 - .122.905 (1985); W. VA. CODE §§ 16-30-1 to -10 (1985); WIS. STAT. ANN. §§ 154.01 - .15 (West Cum. Supp. 1986); WYO. STAT. §§ 33-26-144 to -152 (Cum. Supp. 1986).

[81] "*In re* Quinlan was decided by the New Jersey Supreme Court on March 31, 1976. The California Natural Death Act was enacted on September 30, 1976 and became effective on January 1, 1977." Comment, *Living Wills—A Need for Statewide Legislation*, *supra* note 1, at 800 n.127. *See also* Martyn & Jacobs, *supra* note 4, at 787-88.

[82] At the end of 1977, seven other states had enacted similar statutes: Arkansas, Idaho, Nevada, New Mexico, North Carolina, Oregon, and Texas. Comment, *Living Wills—A Need for Statewide Legislation*, *supra* note 1, at 800.

[83] No other statutes were adopted until 1979 when Kansas and Washington enacted statutes. *Id.*

[84] Fifteen states have either adopted a statute during 1985 or the statutes became effective in 1985. *See* note 80 *supra*.

B. Analysis of Statutory Provisions

More than half of the statutes already in existence begin with a statement of legislative findings or general legislative intent.[85] This section of the statute indicates to patients, physicians and courts the legislature's intent regarding when the statute is to be applied.[86] A statement of legislative intent would be especially appropriate for a living will statute in Kentucky, because there generally are no recorded legislative histories in Kentucky.[87]

As proposed by Kutner,[88] the living will document should parallel the procedural requirements of a last will and testament.[89] The document should state the intentions of the individual who executes it and should be attested by at least two competent witnesses.[90] These procedural requirements put the declarant on notice that the document is important and should be taken seriously.[91]

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[85] Twenty of the thirty-seven states and the District of Columbia have this statement at the beginning of the statute. Some have titled it a "statement of policy" and others have titled it a "directive." ALA. CODE § 22-8A-2 (legislative intent); ARIZ. REV. STAT. ANN. (legislative findings included in historical note); CAL. HEALTH & SAFETY CODE § 7186 (legislative findings and declaration); COLO. REV. STAT. § 15-18-102 (legislative declaration); FLA. STAT. ANN. § 765.02 (policy statement); GA. CODE ANN. § 31-32-1 (legislative findings); IDAHO CODE § 39-4502 (statement of policy); ILL. ANN. STAT. ch. 110 1/2, § 701 (purpose); IOWA CODE ANN. § 144A.1 (policy statement in footnote); KAN. STAT. ANN. § 65-28, 101 (legislative findings and declaration); LA. REV. STAT. ANN. § 1299.58.1 (legislative purpose, findings and intent); MISS. CODE ANN. § 41-41-101 (legislative purpose); N.H. REV. STAT. ANN. § 137-H:1 (purpose and policy); N.J. REV. STAT. § 52:9Y-1 (legislative findings and declarations); N.C. GEN. STAT. § 90-320 (general purpose); TENN. CODE ANN. § 32-11-102 (legislative intent); UTAH CODE ANN. § 75-2-1102 (intent statement); VT. STAT. ANN. tit. 18, § 5251 (purpose and policy); VA. CODE ANN. § 54-325.8:1 (policy statement); WASH. REV. CODE § 70.122.010 (legislative findings).

[86] The legislative intent section of the statute is beneficial to patients and physicians because it indicates when the statute is applicable. The legislative intent is also helpful to courts asked to interpret the statute when questions arise concerning its application. *See* Comment, *Living Wills—A Need for Statewide Legislation*, *supra* note 1, at 801.

[87] Kentucky has no real legislative histories available because very few reports containing committee discussion are published.

[88] Kutner, *supra* note 10, at 48.

[89] *See also* Brown & Truitt, *Euthanasia and the Right to Die*, 3 OHIO N.U.L. REV. 615, 639 (1975-76); Martyn & Jacobs, *supra* note 4, at 789 ("All statutory provisions establishing the use of Living Wills adopt the same procedural requirements as those found in testamentary will provisions."); Note, *supra* note 3, at 509.

[90] Brown & Truitt, *supra* note 89, at 639; Kutner, *supra* note 10, at 48; Note, *supra* note 3, at 509-10.

[91] Martyn & Jacobs, *supra* note 4, at 789.

Because informed consent depends on the individual's ability to make a decision based on all the facts,[92] the individual should be competent[93] and able to make a rational, informed decision[94] at the time the document is executed. "The test of competency is the same as that used to determine the capacity of an individual to execute an agreement . . . whether the person . . . possessed sufficient reason to understand the nature, terms and effect of the agreement."[95] The question is not whether the individual makes a decision that others feel is rational, but whether he had the capacity to make such a decision even though others may disagree with it.[96]

Another requirement that should be included in the statute is that the person issuing the directive be an "adult."[97] Some statutes define adult as a person eighteen years old or older,[98] while others simply have the word "adult" in the statute without defining the term.[99] Because at eighteen years of age a person

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[92] *See* text accompanying notes 52-74 *supra*.

[93] For a discussion of incompetent patients, see notes 100-02 *infra* and accompanying text.

[94] *Cf.* 486 A.2d at 1222 (discussing general requirements for informed consent in treatment refusal situations).

[95] Kutner, *supra* note 10, at 46.

[96] *Id.*

[97] ARK. STAT. ANN. § 82-3803 allows a directive to be issued by others, ILL. ANN. STAT. ch. 110 1/2, § 703(a) allows emancipated minors to issue a directive, N.M. STAT. ANN. § 24-7-4 & LA. REV. STAT. ANN. § 1299.58.6 allow a directive to be issued for terminally ill minors. MD. PUB. HEALTH CODE ANN. § 5-602(a) allows anyone qualified to make a will to issue a directive & TENN. CODE ANN. § 32-11-103(1) allows anyone able to understand and appreciate the nature of the decision to issue a directive. These are the only states that do not have the strict adult requirement.

[98] ARIZ. REV. STAT. ANN. § 36-3201(5); COLO. REV. STAT. § 15-18-103(1); D.C. CODE ANN. § 6-2422(a); GA. CODE ANN. § 31-32-2(2); IDAHO CODE § 39-4503(3); IND. CODE ANN. § 16-8-11-11(a); IOWA CODE ANN. § 144A.2(1); ME. REV. STAT. ANN. § 2922(1); MISS. CODE ANN. § 41-41-105; MO. REV. STAT. tit. 22, § 459.010(2); N.H. REV. STAT. ANN. § 137-H:3; OR. REV. STAT. § 97.050(5); UTAH CODE ANN. § 75-2-1103(3); VT. STAT. ANN. tit. 18, § 5253; W. VA. CODE § 16-30-3(a); WIS. STAT. ANN. § 154.03. OKLA. STAT. ANN. tit. 60, § 3102(5) defines adult as a person 21 years of age or older.

[99] ALA. CODE § 22-8A-4(a); CALIF. HEALTH & SAFETY CODE § 7188; CONN. GEN. STAT. ANN. P.A. 85-606, § 6; DEL. CODE ANN. tit. 16, § 2503; FLA. STAT. ANN. § 765.04(1); KAN. STAT. ANN. § 65-28,103(a); LA. REV. STAT. ANN. § 1299.58.3(A)(1); MONT. CODE ANN. § 50-9-103(1); NEV. REV. STAT. § 449.600; TEX. REV. CIV. STAT. ANN. art. 4590h, § 3; VA. CODE ANN. § 54-325.8:3; WASH. REV. CODE § 70.122.030; WYO. STAT. § 33-26-145(a). ARK. STAT. ANN. § 82-3802 & N.C. GEN. STAT. § 90-321(a)(1) have the word "person" in their statute. MD. PUB. HEALTH CODE ANN. § 5-

generally is deemed to be capable of contracting with others and able to make rational decisions, a living will statute should define adult as such.

The statute also should provide for the rights of those under the age of eighteen, and for those adjudged incompetent. The General Assembly should recognize, as have many courts,[100] that the right to make determinations concerning treatment can be transferred to a guardian or parent[101] and do not cease to exist merely because the patient is a minor or incompetent. A special provision in the statute should make this clear. In the case of a minor, a provision giving the minor a chance to be adjudged competent to make this decision would afford additional protection.[102]

Another important requirement of the statute is a provision regarding pregnant women. If a woman is pregnant when the living will becomes operative, the terms of the will should not be followed during her pregnancy.[103] The state's interest in pre-

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602(a) defines adult as an individual qualified to make a will & N.M. STAT. ANN. § 24-7-3(A) defines adult as a person having reached the age of majority.

[100] 405 N.E.2d 115 (right to refuse treatment may be exercised through "substituted judgment" by a guardian); 357 N.W.2d 332 (conservator authorized to order removal despite lack of specific provision in statutes allowing it); 486 A.2d 1209 (guardian allowed to make decision if either of two tests are met). *Cf.* 370 N.E.2d 417 (judiciary must make final decision of whether duty can be delegated); *In re* Storar, 420 N.E.2d 64 (N.Y.) (state cannot delegate *parens patriae* duty over those who have never clearly expressed wishes), *cert. denied,* 454 U.S. 858 (1981).

[101] A competent adult has the right to refuse medical treatment. . . .

> We now hold that this right rises to the level of a constitutional right which is not lost because of the incompetence or youth of the patient. . . . We conclude that the right to refuse treatment or indeed to terminate treatment may be exercised by the parents or legal guardian of the infant.

321 S.E.2d at 722.

[102] *See, e.g.,* ILL. ANN. STAT. ch. 110 1/2, § 703 ("An individual of sound mind and having reached the age of majority or having obtained the status of an emancipated person pursuant to the 'Emancipation of Mature Minors Act' . . . may execute a document . . . .").

[103] ALA. CODE § 22-8A-4(a); ARIZ. REV. STAT. ANN. § 36-3205(D); CAL. HEALTH & SAFETY CODE § 7188 (included in directive); CONN. GEN. STAT. ANN. P.A. 85-606, § 5; DEL. CODE ANN. tit. 16, § 2503(d); FLA. STAT. ANN. § 765.08; GA. CODE ANN. §§ 31-32-3(b) (in directive), & 31-32-8(a)(1); ILL. ANN. STAT. ch. 110 1/2, § 703(c); IND. CODE ANN. § 16-8-11-11(d); IOWA CODE ANN. § 144A.6(2); KAN. STAT. ANN. § 65-28,103(a); MD. PUB. HEALTH CODE ANN. § 5-605(2); MISS. CODE ANN. § 41-41-107(1) (included in directive); MONT. CODE ANN. § 50-9-202(3); NEV. REV. STAT. § 449.610 (included in directive); TEX. REV. CIV. STAT. ANN. art. 4590h, § 3 (included in directive); UTAH

serving the life of the unborn fetus[104] should override the wishes and intent of the mother, expressed in the living will, at least during the course of the pregnancy. The state's interest should prevail because it cannot be assumed that, if the patient were able to communicate her wishes, she would want to terminate her life support during her pregnancy.[105] The state may also have an interest in keeping the mother alive if the baby can survive because the child will need the mother.[106] If, however, the mother's situation is unchanged after the child's birth, her wish to have medical treatment terminated should be granted.

All living will statutes should have a provision stating that the physician and the hospital shall not be held civilly or criminally responsible for carrying out the wishes of the patient as expressed and directed in the living will document.[107] Without this provision some physicians or hospitals would refuse to follow the document's directive for fear of prosecution.[108] Similarly, many of the statutes also provide that when a physician refuses

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CODE ANN. § 75-2-1109; WASH. REV. CODE § 70.122.030(1) (included in directive); WIS. STAT. ANN. § 154.03 (included in directive).

[104] Although abortions have been legal since *Roe*, the state does have an interest in the life of the unborn fetus during the third trimester of pregnancy. *See* note 18 *supra*.

[105] If the unborn fetus has reached the point of viability—the point at which the fetus could live outside the womb—the mother legally could not choose to die and thus abort the fetus.

[106] Application of President and Directors of Georgetown College, Inc., 331 F.2d 1000, 1008 (1964).

[107] ALA. CODE § 22-8A-7; ARIZ. REV. STAT. ANN. § 36-3205(c); ARK. STAT. ANN. § 82-3804; CAL. HEALTH & SAFETY CODE § 7190; COLO. REV. STAT. § 15-18-110(1)(b); CONN. GEN. STAT. ANN. P.A. 85-606, § 2; DEL. CODE ANN. tit. 16, § 2505(a); D.C. CODE ANN. § 6-2427(a); FLA. STAT. ANN. § 765.10(1); GA. CODE ANN. § 31-32-7; IDAHO CODE § 39-4507; ILL. ANN. STAT. ch. 110 1/2, § 707; IND. CODE ANN. § 16-8-11-14(d)(2); IOWA CODE ANN. § 144A.9; KAN. STAT. ANN. § 65-28,106; LA. REV. STAT. ANN. § 1299.58.8(A)(1)-(2); ME. REV. STAT. ANN. tit. 22, § 2927; MD. PUB. HEALTH CODE ANN. § 5-607(c); MISS. CODE ANN. § 41-41-117(1); MO. REV. STAT. § 459.040; MONT. CODE ANN. § 50-9-204(1)-(2); NEV. REV. STAT. § 449.630; N.H. REV. STAT. ANN. § 137-H:9; N.M. STAT. ANN. § 24-7-7; N.C. GEN. STAT. § 90-321(h); OKLA. STAT. ANN. tit. 60, § 3106; OR. REV. STAT. § 97.065(2); TENN. CODE ANN. § 32-11-110(h); TEX. REV. CIV. STAT. ANN. art. 4590h, § 6; UTAH CODE ANN. § 75-2-1114; VT. STAT. ANN. tit. 18, § 5259; VA. CODE ANN. § 54-325.8:8; WASH. REV. CODE § 70.122.060(2); W. VA. CODE § 16-30-7(a); WIS. STAT. ANN. § 154.07; WYO. STAT. § 33-26-149.

[108] It should be noted, however, ". . . apparently no prosecutor has proceeded to trial where a physician chose to terminate life-preserving treatment or omit emergency treatment in a hopeless case." 405 N.E.2d at 121 (citation omitted). *See also* PRESIDENT'S COMMISSION REPORT, *supra* note 2, at 34-37.

to follow the directive he should not be held liable, but rather should be required to transfer the patient to a physician who will carry out the patient's wishes.[109] This provision is necessary, because if the physician is allowed to ignore the directive, the patient's intent and the legal effect of the living will are frustrated.

To resolve the controversy surrounding the right to die and the exercise of this right, legislation recognizing living wills should be adopted in Kentucky. Legalizing the living will should alleviate the burdens on the courts and guarantee a terminally ill person his right of privacy and the ability to make his own health care decisions.

The following is a statute proposed for adoption by the Kentucky General Assembly. Portions of the statute are taken from other states' statutes and other portions are from the statute proposed by Gerta Bendl.[110]

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[109] ALA. CODE § 22-8A-8(a); ARIZ. REV. STAT. ANN. § 36-3204(B); CAL. HEALTH & SAFETY CODE § 7191(b); COLO. REV. STAT. § 15-18-113(5); D.C. CODE ANN. § 6-2427(b); FLA. STAT. ANN. § 765.09; GA. CODE ANN. § 31-32-8(b)(1); ILL. ANN. STAT. ch. 110 1/2, § 706(c); IND. CODE ANN. § 16-8-11-14(e); IOWA CODE ANN. § 144A.8; KAN. STAT. ANN. § 65-28,107(a); LA. REV. STAT. ANN. § 1299.58.7(B); ME. REV. STAT. ANN. tit. 22, § 2926; MD. PUB. HEALTH CODE ANN. § 5-604(b); MISS. CODE ANN. § 41-41-115(2); MO. REV. STAT. § 459.030; N.H. REV. STAT. ANN. § 137-H:6(II); OKLA. STAT. ANN. tit. 60, § 3107(B); OR. REV. STAT. § 97.070(3); TENN. CODE ANN. § 32-11-108(a); UTAH CODE ANN. § 75-2-1112(2); VT. STAT. ANN. tit. 18, § 5256; VA. CODE ANN. § 54-325.8:7; WASH. REV. CODE § 70.122.060(2); W. VA. CODE § 16-30-7(b); WIS. STAT. ANN. § 154.07; WYO. STAT. § 33-26-147.

In addition, CAL. HEALTH & SAFETY CODE § 7191(b); COLO. REV. STAT. § 15-18-113(5); D.C. CODE ANN. § 6-2427(b); KAN. STAT. ANN. § 65-28,107(a); MO. REV. STAT. § 459.045(1); OKLA. STAT. ANN. tit. 60, § 3107(B); UTAH CODE ANN. § 75-2-1112(3); & WIS. STAT. ANN. § 154.07 make the physician liable for unprofessional conduct for refusing to follow the directive or transfer the patient to a doctor who will follow the directive. ME. REV. STAT. ANN. tit. 22, § 2928(1) provides that willful failure to transfer the patient is a Class E crime. MD. PUB. HEALTH CODE ANN. § 5-607(a) subjects physicians who refuse to transfer a patient to civil liability, while MONT. CODE ANN. § 50-9-206(1) treats the failure to transfer as a misdemeanor. Finally, TENN. CODE ANN. § 32-11-108 provides that a failure to make a good faith effort to transfer the patient subjects the physician to civil liability and professional disciplinary action.

[110] *See* note 8 *supra*. Unless otherwise indicated by footnotes, the statute proposed by this Comment was taken from Gerta Bendl's proposed statute. Ms. Bendl's statute was used because it is substantially similar to many of the state statutes already in force. Portions of Ms. Bendl's statute were changed and taken from other statutes because in the author's opinion they better express the propositions involved.

C. *The Proposed Statute*

§ 1. The general assembly finds that all persons have the fundamental right to control the decisions relating to their own medical care, including the decision to have medical or surgical means or procedures calculated to prolong their lives provided, withheld or withdrawn.[111]

§ 2. In order that the rights of persons with such terminal conditions may be respected even after they are no longer able to participate actively in decisions concerning themselves, the general assembly hereby declares that the laws of the Commonwealth of Kentucky shall recognize the right of a person to make a written declaration, at any time, instructing the person's physician to withhold or withdraw life-prolonging procedures in the event such person is diagnosed as having a terminal condition.

§ 3. As used in this act:

(A) "Attending physician" means the physician who has primary responsibility for the treatment and care of the patient.

(B) "Declaration" means a witnessed document in writing, voluntarily made, at any time, by the declarant in accordance with the requirements of § 4 of this act.

(C) "Life-prolonging procedure" means any medical procedure, treatment or intervention which (1) utilizes mechanical or other artificial means to sustain, restore or supplant a spontaneous vital function or is otherwise of such a nature as to afford a patient no reasonable expectation of recovery from a terminal condition and (2) when applied to a patient in a terminal condition, would serve only to prolong the dying process. "Life-prolonging procedure" shall not include the administration of medication or the performance of any medical procedure deemed necessary to provide comfort or sustenance care or to alleviate pain.

(D) "Physician" means a person licensed to practice medicine in the Commonwealth of Kentucky.

(E) "Qualified patient" means a patient who has:

(1)Made a declaration in accordance with this Act; and

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[111] This section contains the legislative intent as discussed in notes 85-87 *supra* and accompanying text. This section was included in the Bill proposed by Gerta Bendl, however, her version contained "competent adult" which the author replaced with "all persons".

(2)Been diagnosed and certified in writing by the attending and one other physician, as having a terminal condition.

(F) "Terminal condition" means a condition caused by injury, disease or illness from which, to a reasonable degree of medical certainty, there can be no recovery or death is imminent and where the application of life-prolonging procedures would serve only to artificially prolong the dying process.

§ 4. Any person who has attained the age of eighteen years old or who has been adjudged by a court to be competent to make the decision may make a written declaration directing the withholding of life-prolonging procedures when such person is diagnosed as having a terminal condition. The test for competency shall be whether the individual is able to understand and appreciate the nature and consequences of the decision.[112]

§ 5. A written declaration shall be signed by the declarant in the presence of two subscribing witnesses.[113] In no instance shall any of the following be a witness to any declaration made under this act:

(a) A blood relative who would be a beneficiary of the declarant; or

(b) A beneficiary of the declarant under descent and distribution statutes of the Commonwealth; or

(c) An employee of a health facility in which the declarant is a patient; or

(d) An attending physician of the declarant; or

(e) Any person directly financially responsible for the declarant's health care.

§ 6. It shall be the responsibility of the declarant to provide for notification to the declarant's attending physician that a declaration has been made. In the event the declarant is comatose, incompetent or otherwise mentally or physically incapable, any other person may notify the physician of the existence of a declaration. An attending physician who is so notified shall promptly make the declaration or a copy of the declaration a part of the declarant's medical records.

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[112] *See, e.g.,* TENN. CODE ANN. 32-11-103(1); MO. REV. STAT. § 459.010(2).

[113] *See* notes 88-91 *supra* and accompanying text.

§ 7. Life-prolonging procedures may be withheld or withdrawn from an adult patient with a terminal condition who is comatose, incompetent, or otherwise physically or mentally incapable of communication and has not made a declaration in accordance with this act if there is a consultation and a written agreement for the withholding or withdrawal of life-prolonging procedures between the attending physician and any of the following individuals, who shall be guided by the express or implied intentions of the patient, in the following order of priority if no individual in a prior class is present:

(a) The judicially appointed guardian of the person if such guardian has been appointed. This paragraph shall not be construed to require such appointment before a treatment decision can be made under this section.

(b) The patient's spouse.

(c) The parents of the patient.[114]

§ 8. A declaration made pursuant to this act shall be in the following form, and may include other specific directions if the declarant so wishes. Should any other specific directions be held to be invalid, such invalidity shall not affect the declaration.

DECLARATION

Declaration made this _____ day of _____.

I, _____, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, and do hereby declare:

If at any time I should have a terminal condition and my attending and one (1) other physician have determined that there can be no recovery from such condition and where the application of life-prolonging procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort or sustenance care or to alleviate pain.

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[114] *See, e.g.*, LA. STAT. ANN. § 1299.58.6; UTAH CODE ANN. § 75-2-1107(2)(b). *See* notes 88-90 *supra* and accompanying text.

In the absence of my ability to give directions regarding the use of such life-prolonging procedures, it is my intention that this declaration shall be honored by my family and attending physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences for such refusal.

If I have been diagnosed as pregnant and that diagnosis is known to my physician, this directive shall have no force or effect during the course of my pregnancy.

I understand the full import of this declaration and I am emotionally and mentally competent to make this declaration.

_____

Signed

The declarant is known to me and I believe the declarant to be of sound mind.

_____

Witness

_____

Witness

§ 9. No declaration executed in accordance with the above, shall be revoked except in the presence of two witnesses and:

(a) By some writing declaring an intention to revoke, which writing shall be signed and dated by the declarant; or

(b) By an oral statement by the declarant of an intent to revoke; or

(c) By the declarant or by some person in the declarant's presence and at the declarant's direction, by cutting, tearing, burning, obliterating, canceling, or destroying the declaration, or the signature thereto, with the intent to revoke.

§ 10. An oral statement by the declarant to revoke a declaration shall override any previous written declaration.

§ 11. Any such revocation shall become effective when communicated to the declarant's physician. The attending physician shall record, in the declarant's medical record, the time, date

and place when the physician received notification of the revocation.

§ 12. The living will declaration of a person who is diagnosed as pregnant by the attending physician shall have no effect *during the course of the pregnancy.*[115]

§ 13. A health care facility, physician or other person acting under the direction of a physician shall not be subject to criminal prosecution or civil liability or be deemed to have engaged in unprofessional conduct as a result of the withholding or the withdrawal of life-prolonging procedures from a patient with a terminal condition in accordance with this act. A person who authorizes the withholding or withdrawal of life-prolonging procedures from a patient with a terminal condition in accordance with a qualified patient's declaration shall not be subject to criminal prosecution or civil liability for such action.[116]

§ 14. The provisions in this section shall apply unless it is shown by a preponderance of the evidence that the person authorizing or effectuating the withholding or withdrawal of life-prolonging procedures did not, in good faith, comply with the provisions of this act. A declaration made in accordance with this act shall be presumed to have been made voluntarily.

§ 15. An attending physician who refuses to comply with the declaration of a qualified patient shall transfer the patient to another physician who will carry out the declaration. Failure to effect a transfer shall constitute unprofessional conduct.[117]

§ 16. The withholding or withdrawal of life-prolonging procedures from a qualified patient in accordance with the provisions of this act shall not, for any purpose, constitute a suicide. No policy of life insurance shall be legally impaired or invalidated by the withholding or withdrawal of life-prolonging procedures from an insured qualified patient, notwithstanding any term of the policy to the contrary.

§ 17. Any person who willfully conceals, cancels, defaces, or damages the declaration of another without the declarant's consent or who falsifies or forges a revocation of the declaration

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[115] *See, e.g.*, IND. CODE ANN. § 16-8-11-11(d).

[116] *See* notes 107-08 *supra* and accompanying text.

[117] *See, e.g.*, COLO. REV. STAT. § 15-18-113(5).

of another, thereby causing life-prolonging procedures to be utilized in contravention of the previously expressed intent of the patient, shall be civilly liable.

§ 18. Any person who falsifies or forges the declaration of another, or willfully conceals or withholds personal knowledge of the revocation of a declaration, with the intent to cause a withholding or withdrawal of life-prolonging procedures, contrary to the wishes of the declarant, and thereby, because of such act, directly causes life-prolonging procedures to be withheld or withdrawn and death to be hastened, shall be guilty of a felony.

CONCLUSION

A number of courts have extended the right of privacy to include the right to refuse medical treatment.[118] This right has been extended further by some courts to allow the right to withdraw medical treatment when the patient has no hope of recovery.[119] Enforcement of this right in court, however, takes a lot of time, a lot of money and in some cases the patient may die before the case is finally adjudicated. The legislature, therefore, should enact the living will statute as a means to effectuate a recognized right. Allowing a patient to express this right beforehand will save the family from unnecessary agony and the expense of going to court. It also removes the decision from the physician and the family and leaves it where it should be, with the patient.

Michelle Coulter Landers

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[118] *See* note 20 *supra*.

[119] *See* Brophy v. New England Sinai Hosp., Inc., 497 N.E.2d 626 (Mass. 1986) wherein the Massachusetts Supreme Court recently went farther than any other court has gone in allowing medical treatment to be withdrawn from a patient. Mr. Brophy was in a persistent vegetative state and was getting nutrition through a gastronomy tube. His family wanted the tube removed. *Id.* at 628. The court held that Mr. Brophy had a right to have the tube removed and therefore he had to be transferred to a hospital that would carry out his wishes. *Id.* at 639.